PRINTED: 09/27/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR	RUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 0	0	COMPLETED	
	155417	D. WING		09/09/2011	

NAME OF PROVIDER OR SUPPLIER

NAME OF	PROVIDER OR SUPPLIER		GARDNER AVE	
HICKOR	RY CREEK AT SCOTTSBURG	SCOTT	SBURG, IN47170	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000				
	This visit was for a Recertification and State Licensure Survey. Survey Dates: September 6, 7, 8, and 9, 2011 Facility Number: 000421 Provider Number: 155417 Aim Number: 100288340	F0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
	Survey Team: Gloria J. Reisert MSW TC Dorothy Navetta RN Census Bed Type: SNF/NF: 31		Hickory Creek at Scottsburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 9, 2011.	
	Total: 31 Census Payor Type: Medicare: 06 Medicaid: 20 Other: 05 Total: 31			
	Sample: 10 Supplemental Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.			
	Quality review completed 9/14/11			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNMZ11

Facility ID:

000421

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		155417	B. WING	·		09/09/20	D11
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
HICKUD	Y CREEK AT SCOT	TSRUDG			GARDNER AVE SBURG, IN47170		
					ODONG, IIN#7 170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
IAG			-	IAG	DEFICIENC!)		DATE
F0244 SS=E	Cathy Emswiller RN When a resident of acility must listen the grievances and residents and family policy and operation resident care and I Based on record interviews, the factoriers regarding the factoriers regarding and the factorier residents, 1 of 3 and 8 Resident Counciliers (a) and the factoriers (b) and the factoriers (c) and the factoriers (c) and the factoriers (c) and the factoriers (c) and the same as of replacements. Respectively the factoriers (c) and the same as of replacements (c) and the factoriers (c) and the same as of replacement are comprehences. Will what is on the meaning the factoriers (c) and the meaning (c) and the factoriers (c) and the same as of replacements. Respectively (c) and the same as of replacement are comprehences. Will what is on the meaning (c) and c) are sident of the same as of the factoriers (c) and c) are sident of the same as of the factoriers (c) and c) are sident of the same as of the factoriers (c) and c) are sident of the same as of the factoriers (c) and c) are sident of the same as of the factoriers (c) and c) are sident of the same as of the factoriers (c) and c) are sident (c) are sident (c) and c) are sident (c) are sident (c) and c) are sident (c) are si	r family group exists, the to the views and act upon direcommendations of lies concerning proposed onal decisions affecting life in the facility. review, observation and ocility failed to resolve and food preferences fidential group meetings and and reliable resident interviews, 1 of ceil minutes and 1 of 2 is (Residents #50, 51, 52, 66) 1/2011 Resident Council 1011 at 1:00 p.m., owing concern voiced Manager's response:" written and returned by however meals on menus redered. Too many esponse: Most of the due to diet or residents strive to have exactly enu each day. Will try to all replacements. Was	F0.	244	F244 It is the policy of this facility to listen to the views and act upon grievances and recommendation of residents and families concerning proposed policy an operational decisions affecting resident care and life in the facincluding residents' choice regarding food preferences. 1. What corrective action will be accomplished for those resident found to have been affected by deficiency? Menus for every resident were checked to verify that each resident each one chose. If the resident's selective menuris not returned to the kitchen or selective menu paper is incomplistaff member will take a selective menu to the resident prior to ser to allow his/her choice of the form that is being served. Alternate food choices will be promptly discussed with and provided to each resident. The Resident Council concern for the April minutes was under the responsibility of the previous D. Services Manager. A Teachable	n the ons d cility ee uts the lete, a ve ving od	10/08/2011
	During the confid	dential group meeting on			Moment (discipline) has been g	- 1	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	MNMZ11	Facility I	ID: 000421 If continuation sh	neet Pac	ge 2 of 31

I '		(X2) MULT	TIPLE CON	ISTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	
		155417	B. WING			09/09/2	011
NAME OF I	DROVIDED OD SLIDDI IED		S	TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	1	1100 N G	GARDNER AVE		
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTTS	BBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	1	AG			DATE
		p.m., 6 of 7 residents			to the current Dietary Services Manager regarding the need to		
	`	51, 53, 54, 55, and 56)			residents' food preferences.	1101101	
	· ·	ented and reliable by the			residents food preferences.		
	Director of Nursi	ing [DoN] on 9/9/2011 at			All Staff were re-educated on		
	noon, voiced the	following concerns: not			Sept.20, 2011 regarding promp	<u>tly</u>	
	always following	g the selective menus			resolving concerns for food		
	choices, seldom	bring what was ordered,			preferences.		
	run out of desser	t ordered when get to the			- Activity Director and Dietary		
		equent excuses and			Manager were re-educated on S	Sent	
	substitutes.	•			19, 2011 regarding follow up to		
					concerns written from Resident	_	
	During an intervi	iew with the Activity			Council.		
	_	2011 at 12:05 p.m., he			-		
		cording to the facility's			-		
		each department head had			2.How will the facility identify other residents having the	<u>v</u>	
		_			potential to be affected by the		
		y were responsible for.			same practice and what correct	_	
	•	head was supposed to go			action will be taken?		
		o make sure the resident			-		
		ir menu and had filled in			All staff was educated on 9-20-		
		Ie indicated sometimes			monitor residents' selective me		
	_	got and left it on their			and to ensure that items selected what are received.	<u>a are</u>	
		why their assigned			mut are received.		
		osed to go behind and			Meal delivery staff will check e	each_	
		ndicated that if the			individual resident's menu agai		
	resident left a sec	ction blank, i.e. the			what is being served as trays ar		
	vegetable, meat,	etc. then they got the *			delivered. If the meal delivery s		
	[star] item wheth	er it was to their liking or			finds that a resident has not bee served food according to his/he		
	not. He indicated	he felt that this may be			choice, the staff will take the fo		
	one of the reason	is the resident thought			back to the dietary department,		
	they were getting	g something they did not			for the proper replacement as		
	order.				indicated by the resident's choice		
					and deliver it to the resident. On		
	The Activity Dire	ector indicated that he did			that is done, the Dietary Service		
	-	when the residents had			Manager will review the need f	<u>or</u>	
	I HOL WITH GOWII V	viicii uic residellis liad					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/09/2011
	PROVIDER OR SUPPLIER		STREET A 1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	food complaints Resident Counci directly to the Di know of the cond During the noon 9/7/2011 at 12:1 was brought her she received was an interview at the indicated she did tomatoes and did sprouts also on the she was able to we did not like what yes but that she li	unless it had to do with l. He would instead go letary Manager and let her	IAU	following the selective menus designated by the resident with staff involved in the noncomple. Progressive disciplinary action be done for instances of continuoncompliance. 3. What measures will be into place to ensure this practice does not recur? The DSM or designee will review the selective menuday prior to the scheduled meals to ensure no replacements will be need the DSM identifies food choices that are not readile available she will make so that item(s) are purchased promptly. Any necessary menu chan will be completed prior to printing of selective menuand posting of meal for the day. Dietary Service Manager or he designee/cook for each meal we come into dining rooms and as that residents are satisfied with received. The DSM will address an identified issues with the as indicated in question #	as in the iance. in will inded e put I led. If y ire I mages is see er iill issess in food y staff 2.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	ROVIDER OR SUPPLIER		STREET A 1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE 'SBURG, IN47170	1
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				monitored to ensure the defice practice does not recur and we OA will be put into place? Through the facility Angel Prodepartment managers assist resus as needed with completing their menus and ensuring they return kitchen prior to the day the meto be served. Residents who procomplete the selective menus cown will continue to be encour to do so. Residents who prefer complete their selective menus who are unable to do so on the will receive assistance of staff. With a resident concern, the Didesignee reviewing selective mand meals will pull paper menus after resident needs are met, stay will document concern to assist tracking with the QA audit form F244. Concerns documented on the prefer menus, will be brought to the redaily interdisciplinary team metor review. The QA audits will be brought monthly QA&A Committee methat is attended by the medical director for review and recommendations. The QA audit form F-244 be completed weekly for the next month, then twice a month for the next 30 day After that time, it will be completed once a month of the complete once and th	gram, idents ir not the als are efer to on their aged not to or ir own. SM or menus is. aff to in m. aper text eeting to the eeting. To will the second or in the eeting of the eeting of the eeting.

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/09/20	ETED
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170		
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F0282 SS=D	facility must be proin accordance with plan of care. Based on record facility failed to to decrease the doanti-inflammator #6) and to admin medication as ord. The facility also pulse checks were by the physician. deficient practice residents in a san of 1 residents in a	ded or arranged by the ovided by qualified persons a each resident's written review and interview, the follow physician's orders osage for 1 of 1 resident's y medication (Resident ister the antipsychotic dered (Resident #26). failed to ensure daily e completed as ordered (Resident #28). This affected 2 of 10 mple of 10 residents and 1 a supplemental sample of ewed for medication and	F0	282	ongoing basis until the fact has achieved 100% compliance. At that point, QA&A Committee can dec whether or not to continue written audit documentation. This process and review of daily selective menus will continue on an ongoing base even when documented au are no longer required by the QA&A Committee. Date of compliance: October 8 2011. F282 It is the policy of this facility the services must be provided by qualified persons in accordance with each resident's written plof care including the need to for physician orders for medication administration and vital signs. 1. What corrective action(s) with accomplished for those resider found to have been affected by deficient practice? 1. Medication (Motrin) for Resident was added to the Medication Administration Record on Augu 2011.	the cide the on. If the sis dits he sis dits dits dits dits dits dits dits	10/07/2011

000421

li ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155417	B. WIN	G		09/09/2	011
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William Of	I KO VIDEK OK SOI I EIEF			1	GARDNER AVE		
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170		
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	Finding includes	:			2. The MD was notified of puls		
					checks for Resident #28 on 9/9/ MD gave a new order to discon		
	1. Review of the	clinical record for			daily pulse checks and to check		
	Resident #6 on 9	0/8/2011 at 10:05 a.m.,			every other day with Digoxin o	-	
	indicated the res	ident had diagnoses			<u>9/9/11.</u>	_	
	which included,	but were not limited to,			3. Medication Administration R		
	1	steoarthritis, immobility			was corrected for Resident #26	order	
	syndrome, and o	•			for Seroquel on 9/7/11.		
		1			The DON will provide re educato the nurses/QMAs on 9/28/11		
	On 8/22/2011 th	ne consultant pharmacist			include review of Pharmacy	10	
	made the following recommendation:				recommendations and transcrip	tion	
					of orders for medication change		
	"[resident] has been receiving Motrin [a non-steroid anti-inflammatory drug] 400				vital sign monitoring.		
					_		
		BID [twice daily] since			-		
	1	thritis pain, I presume.			- 2 H	41	
	1	s Aspirin 81 mg QD			2. How other residents having potential to be affected by the		
	1	ovascular prophylaxis.			same practice will be identified		
	1	te long term use of			and what corrective action(s)		
	Motrin, especial	ly as she is getting older			be taken?		
	now. Long term	use is associated with			<u>-</u>		
	elevated blood p	ressure, worsening			1. A Pharmacy recommendation		
	kidney function,	cardiovascular events			audit was completed on 9/12/11 other residents were found to be		
	and GI [gastroin	testinal] effects."			affected by this alleged deficier		
					practice.		
	On 8/26/2011. th	ne physician agreed and			2. & 3. An audit will be conducted	cted_	
		r to decrease the Motrin			by 9/30/11 on all monthly rewri	ites to	
	to 200 mg po [by				make sure that they are accurate		
		, mouni Bib.			preparation for the review of the		
	Review of the A	ugust MAR [Medication			October monthly physician order	ers.	
		Record] indicated the			As the DON is reviewing the		
		t into effect until			September monthly physician of	rders	
	1				and any physician orders subsec		
		ng an interview with the			to it, she will identify any issue		
		ing [DoN] on 9/8/2011 at			concerns regarding physician or		
	2:00 p.m., she in	dicated one of the nurses'			and will make sure that the phy	sician	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU			(X2) M	ULTIPLE CO	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155417	A. BUI	LDING	00	09/09/2011
		133417	B. WIN			09/09/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170	
		TATEMENT OF DEFICIENCIES		ID		(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
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	found the consult	ant's recommendation			is notified, as necessary, for	
	and the physician	s's response on a clip			clarification. Once the orders ar	
		r which was why the			complete and accurate, the DON	<u>N will</u>
	medication was n				review the facility's policy for transcription and following of	
	8/30/2011.				physician orders with the nurse((s)
					involved. She will also render	
					progressive disciplinary action to	<u>for</u>
	2. Review of the	clinical record for			continued noncompliance.	
	Resident #28 on	9/7/2011 at 3:15 p.m.,			- 2 What magazing will be	nu.
		dent had diagnoses			3. What measures will be	
		out were not limited to,			into place or what system changes will be made to	<u> </u>
		isease, atrial fibrillation			ensure that the deficient	
	and hypertension				·	
	31				practice does not recur?	
	The 2011 Septem	ber monthly physician			- 1. The DON will review	z the
	orders indicated t	the resident had an order			24 hour report, focus chart	
	dated 7/19/2010	for pulse checks every			Medication Administration	
	day. Review of th	ne May to August 2011			Record, and Physician order	
	MARs lacked do	cumentation of the pulse			at least five times a week a	
	being monitored	on a daily basis. Review			part of her daily tour of du	
	of the MARs ind	icated the pulse was only			2. Pharmacy	iy.
	being monitored	every other day due to			recommendations will be	
	the use of Digoxi				given to the nurses to fax to	
		-			the MDs. The MDs that do	
	During an intervi	ew with the DoN on			receive faxes will be called	
	•	a.m., she indicated she			regards to the	· ····
		e pulse was not being			recommendations. If no	
		per physician orders and			response is received within	. 24
		ll the physician to			hours, the Physician will b	
		soning for it being			contacted by phone for following	
		and if he wanted it to			up. The DON will in-servi	
	continue to be me				all licensed nurses on this	
		•			policy on 9/28/11.	
					policy on 7/20/11.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155417	B. WIN	G		09/09/2011
	ROVIDER OR SUPPLIER		-	1100 N	.ddress, city, state, zip code GARDNER AVE SBURG, IN47170	
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					At least five days per week the DON or designee, will review the 24 hour report, focus charting, Medication Administration Record, an Physician orders for any outstanding recommendation or change of orders. The Dor designee will document findings on audit tool QA aform F282, five days per will the DON identifies recommendations not addressed by the Physician new orders not processed, will immediately ensure that attending Physician is notional process any orders. On they have been corrected, to DON will re train the staff member(s) involved. In addition, progressive disciplinary actions will be taken for non compliance. 4. How will corrective action be monitored to ensure the deficipractice does not recur and will part to place?	ons OON audit veek. or she he fied hee fied hee the ce the fied
					The DON or designee will bring QA audits to the clinical review meeting 5 days a week. In addit	<u>'</u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 09/09/2011	Y
	PROVIDER OR SUPPLIER		STREET A 1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	'	
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	3. On 9/7/2011 a observation of the Resident # 26 did 25 m.g. (milligrated In an interview where we will be will be will be a seroquel 25 m.g. attempted to decemte at 5:00 p.m. On 9/7/2011 at 5 clinical record for the seroquel for the seroquel for the seroquel at 5:00 p.m.	t 4:30 p.m., during an e medication pass, d not receive her Seroquel ams) po (by mouth). with RN (Registered as time, she indicated that as supposed to get and that when they rease the dosage from 25 5 m.g., the patient al, so they had to increase as RN # 1 indicated that d the Seroquel be given 1:00 p.m., review of the particular review of t		the results of the QA audit to be reviewed weekly at the St of Care meeting and monthly QA committee meeting for the months. The QA committee will dete the continued frequency of the audit tools after the 3 month period once the facility demo 100% compliance. However review process as outlined all continue on an ongoing basis when the Committee no long requires a written audit. Date of compliance is Octob 2011.	andards y at the ne next 3 mine ne QA time onstrates the ove will s, even er	

					NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155417		LDING	00	09/09/2	
		100417	B. WIN		DDDEGG CITY GTATE ZID CODE	00/00/2	011
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	-	lementia, psychosis, and					
	dementia with be	chaviors disturbances.					
	The Medication	Administration Record					
		ocumentation that any					
	` ′	en given from 9/1/2011 to					
	•	AR indicated, but was					
		n 8/26/2011 Seroquel 25					
		ossed out with a yellow					
	highlighter and the	•					
	(discontinued) written across it. Physician						
	` ′	but were not limited to;					
	"8/26/2011 decrease Seroquel to 12.5 mg						
	Q (every) HS (at						
	· · · · · · · · · · · · · · · · · · ·	der for Seroquel 12.5					
		lded to the MAR.					
	Physician orders	indicated, but were not					
	limited to; on "9	$1/1/2011 \uparrow \text{ (sign for }$					
	increase) Seroque	el to 25 mg Q HS". The					
	MAR indicated of	on 9/1/2011 that the					
	Seroquel 12.5 m.	g. had been crossed out					
	, ,	ghlighter and the letters					
		ross it. Documentation					
	_	the Seroquel 25 m.g. was					
	added back on th	e MAR.					
	A physician orde	er dated 9/7/2011					
		e Seroquel may be given					
	at 5:00 p.m.	2 22134401 11141 00 51 1011					
	р.ш.						
	3.1-35(g)(2)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155417			(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE : COMPI 09/09/2	ETED
	PROVIDER OR SUPPLIER Y CREEK AT SCOT			STREET A	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0323 SS=E	The facility must environment remainst hazards as is possible receives adequated devices to prevent A. Based on observe of review, the hazardous materiproperly on 1 of a deficient practice affect 2 of 10 results and 30) and 6 of residents (Reside 31) identified as a dementia in a cercurrently in the facility failed thoroughly invest factors for 1 of 10 skin impairments residents. (Reside Findings include: A. After the ground 3:05 p.m., the folian unlocked cabinated with the service of the facility failed thoroughly investigations. (Reside 5) p.m., the folian unlocked cabinated for the facility failed thoroughly investigations.	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. ervation, interview and e facility failed to ensure als were secured 4 survey days. This had the potential to idents (Residents #26 10 supplemental nts #3, 11,19, 24, 28 and ambulatory with assus of 31 residents accility. In review and interview, to ensure a bruise was tigated for causative 0 residents reviewed for a sample of 10 ent #6)	F0	323	F323 It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents including securing of hazardous materials and thore investigation of resident injury such as bruising. 1. What corrective action will be accomplished for those resider found to have been affected by deficiency? A. The cabinet was immediately not of incident and directed not to be key in lock when out of the room. B. Per interview of alert and or resident #6, res. indicates that dea transfer she was pinched by the mechanical lift which caused a when assisted to the bathroom. All incident reports will be audifor the last 6 months to ensure the all incidents have been thorough investigated and if possible, causative factors identified by \$30, 2011.	f f pugh v pe nts the tified eave m. ented uring ne bruise	10/08/2011

li '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLE	TED
		155417	B. WIN			09/09/20	11
			P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	GARDNER AVE		
HICKOR'	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,	+	DATE
		e bottle of Derma Tech			All Licensed Nurses will be in-serviced on the procedure fo	_	
	Instant Hand San	itizer. Review of the			investigating incidents, including		
	Material Safety I	Data Sheet [MSDS]			bruises by Sept. 30, 2011.	<u>1g</u>	
	presented by the	Administrator on			2.How will the facility identify	,	
	9/7/2011 at 10:00	a.m., indicated: "May			other residents having the	-	
		on. May cause upset			potential to be affected by the		
	stomach, nausea.				same practice and what corre	_	
	· ·				action will be taken?		
		y from reach of small			A. All staff including the therag		
	children. Will ca	use slippery surfaces."			were re-educated 9-20-11 regar		
					the need for securing all hazard		
	2. a 12 fluid ound	ce bottle of So Natural			materials. All staff was instruct		
	Body Lotion. Re	view of the label on the			remove key(s) from doors or ca		
	bottle indicated "	Keep Out of Reach of			in violation of safety practices.	- I	
	Children".	1			Department managers will mal frequent rounds and monitor se		
	Cilitaren .				areas regularly to ensure hazard		
	2 - 12 8	h - 441 £ D			materials are secured properly a		
		ce bottle of Provon			keys are left in locks.	and no	
	~	nd And Body Lotion.					
	Review of the M	aterial Safety Data Sheet			B. All incident reports will be		
	[MSDS] indicate	d: "May cause eye			brought to the interdisciplinary	_	
	irritation. May ca	nuse upset stomach,		Clinical Meeting 5 days weekly to			
	nausea. Store at 1	normal temperature away			make sure that incidents have b	een	
		all children. Will cause			thoroughly investigated and		
	slippery surfaces				causative factors have been		
	suppery surfaces	•			identified.		
	4 0.7 7 1	1 41 60 1					
		ce bottle of Conductor			3.What measures will be	<u>put</u>	
		1. Review of the Material			into place to ensure this		
	Safety Data Shee	et [MSDS] indicated:			practice does not recur?		
	"Irritation of the	skin and eyes upon			A. Therapists were re-educated	_	
	prolonged contac	et. Keep Out of Reach of			regarding ensuring hazardous		
	Children."	•			materials are properly secured.	All	
					management and line staff are	. ,	
	5 0 0 7 0 0 0 0 0	n of Fabreeze Air Effects.			monitoring cabinet lock identif		
					and have been instructed to retr	<u>ieve</u>	
		pel on the can indicated			key(s) if found.		
	"Keep Out of Re	ach of Children".					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155417	B. WIN			09/09/2011
			D. (12)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	-			GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170	
						(VI)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
1110	REGULATORIOR	ESC IDENTIFICATION OF THE COMMUNICATION	+	1110	A. The Administrator or	DATE
	6 a agm of A ama l	Diginfortant Bassiass of				lom
	6. a can of Aero Disinfectant. Review of				designee will conduct rand	
		ety Data Sheet [MSDS]			checks throughout the faci	· 1
	_	be irritating to eyes, skin,			on varying shifts 5 days pe	l l
	· ·	mucous membranes. May			week for 30 days, then 3 ti	
		discomfort, nausea,			per week for 30 days to en	sure
	vomiting and dia	rrhea."			hazardous materials are	
					secured properly and no ke	eys
	During an intervi	iew at this time with the			are left in locks.	
	Occupational Therapist #1, she indicated					
that the cabinet was normally locked				In addition to the random		
	because of the items in the cabinet. She				checks done by the	
	indicated that as	a rule, the cabinet was			Administrator or designee,	as
		mputer taken out of the			part of the facility "guardia	an
	· ·	the cabinet was re-locked			angel program" the	
		sed she just forgot this			departments managers sha	11
	time.	sea she jast lorgot this			make frequent rounds and	
	time.				monitor locked areas. If th	e l
	On 9/9/2011 at 9	:00 a m tha			manager(s) identify an	
		esented a copy of the			unsecure area it shall be	
	•	* *			secured immediately and	
	•	policy on "Chemical			reported to the Administra	tor
	_	y of this policy at this			and Therapy Lead staff	101
		Purpose: The purpose of			immediately. The Therapy	
		is to properly store				
		n a designated location.			Lead will ensure the area i	S
	Follow these step				secured at once.	
	_	1. Follow manufacture's				
		s when storing all			Once the resident's needs l	nave
	chemicals. 2. Sec	cure all items labeled			been taken care of, the	
	"Keep Out of Re	ach of Children" out of			Therapy Lead staff will	
	sight from wande	ering residents9.			address the identified issue	e(s)
	Therapy cabinets which contain chemicals				with the involved staff,	
		times when unattended			including re-training as	
	and keys not left	in lock"			necessary and progressive	
	· · · · · · · · · · · · · · · · · · ·				!	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155417	B. WIN	G		09/09/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SUFFLIER			1100 N (GARDNER AVE		
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTTS	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					disciplinary action for		
	On 9/9/2011 at n	oon, the Director of			continued noncompliance.		
	Nursing presente	d a list 8 residents who			The Administrator or designee		
	were identified a	s confused and			document the random checks us		
	ambulatory. (Res	sidents #26, 30, 3, 11, 19,			QA audit form F-323 and bring		
	24, 28 and 31)				results to the Standards of Care meeting at the next scheduled	-	
	, ,				meeting that is held weekly.		
					Department manager "guardian	angel	
	D 1 Davious of t	he clinical record for			program" rounds shall be		
					documented on the "guardian a	ngel	
Resident #6 on 9/8/2011 at 10:05 a.m.,					program" form and the results s	hall_	
		dent had diagnoses			be reviewed by the interdiscipli		
	· ·	but were not limited to,			team at the next scheduled mor		
	cerebral palsy, os	steoarthritis, immobility			management meeting that is he	ld at	
	syndrome, and or	steoporosis.			least 5 days per week.		
					B. As stated above, all incident reports will be brought to the C		
	A 6/22/2011 nurs	sing note indicated the			Meeting 5 days weekly to verif		
		ained a bruise to her			incidents were thoroughly		
	inner upper right	arm - 3 x 1 5 cm			investigated and include causat	ive	
		ole in color - which the			factors. Any interventions that	are_	
		d she had caught it on the			developed as a result of this		
	mechanical lift.	a she had caught it on the			interdisciplinary review will be	_	
	mechanicai iiit.				updated on the resident's care p	<u>lan</u>	
					and CNA assignment sheet.		
	Review of the 6/2				These processes and review		
		the former DoN indicated			will continue on an ongoir	ıg	
	the resident told	her she did it on the			basis.		
	sit-to-stand lift d	uring toileting transfer.			4.How will corrective action b		
	Documentation v	vas lacking of any further			monitored to ensure the defici		
	investigation into				practice does not recur and w QA will be put into place?	nat_	
	happened.				A will be but into blace:		
	11.				A. The Administrator will bring	the	
	During an intervi	iew with the current DoN			results of the QA audits to the v		
	~	40 p.m., she indicated			Standards of Care meeting, the		
		* '			monthly QA&A Committee me	eting	
		e been a more thorough			that is attended by the medical		
	investigation into	how the transfer went,					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CON	ISTRUCTION 00	(X3) DATE S COMPL	
ANDILAN	or connection	155417	A. BUILDI	NG		09/09/2	
			B. WING	TDEET AF	DDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF I	PROVIDER OR SUPPLIER		I		SARDNER AVE		
HICKOR'	Y CREEK AT SCOT	TSBURG			BURG, IN47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u> </u>	ID T	·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE.	DATE
	i.e. resident mov	ed, CNA [certified			director for review and		
	nursing assistant	did not position the			recommendations.	1	
	resident correctly				The QA audit-323 will be		
		ed, etc. The DoN also			5 days a week for 30 days,		
		s not able to track as to			then weekly for the next 30 days. At that time, the audi		
		as at the time of the bruise			tool will continue at a	11	
	to provide any fu	orther information.			frequency determined by the	he	
					QA&A Committee, and ca		
	2.1.45(.\(\)(1)				discontinued by the QA&A		
	3.1-45(a)(1)				Committee when 100%	-	
	3.1-45(a)(2)				compliance is achieved.		
					F		
					This process will continue	on	
					an ongoing basis even whe		
					documented audits are no		
					longer required by the QA	&A	
					Committee.		
					B. All Licensed Nurses will be		
					in-serviced on the procedure for investigating incidents, including		
					bruises by Sept. 30, 2011.	<u>'5</u>	
					-		
					B. As stated above, all incident		
					reports will be brought to the Cl Meeting 5 days weekly to verify		
					incidents were thoroughly	<u>, </u>	
					investigated and include causati	ive_	
					factors.		
					The Director of Nursing will bri	ing	
					the results of the QA audits to the		
					weekly Standards of Care meeti		
					the monthly QA&A Committee	_	
					meeting that is attended by the medical director for review and		
					medical director for feview allu	_	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co		(X3) DATE SURVEY COMPLETED	
MIDILAN	OI CORRECTION	155417	A. BUILDING	00	09/09/2011
		100417	B. WING		03/03/2011
NAME OF F	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
HICKOR'	Y CREEK AT SCOT	TSBURG	I	TSBURG, IN47170	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				recommendations.	1
				The QA audit-323 will be	I
				5 days a week for 30 days	
				then weekly for the next 3	
				days. At that time, the aud	ıt
				tool will continue at a	
			1	frequency determined by t	
				QA&A Committee, and ca	
				discontinued by the QA&.	Α
				Committee when 100%	
				compliance is achieved.	
				This process will continue	on
				an ongoing basis even who	en
				documented audits are no	
				longer required by the QA	&A
				Committee.	
				These processes and revie	ws
				will continue on an ongoir	ng
				basis.	
				Date of compliance: October 8 2011.	<u>3.</u>
F0364		eives and the facility			
SS=F		pared by methods that			
	conserve nutritive appearance; and f	ood that is palatable,			
		he proper temperature.			
	Based on observa	ation, record review and	F0364	<u>F364</u>	10/08/2011
	interview, the fac	cility failed to ensure that		It is the policy of this facility t	<u>hat</u>
	the temperatures	s were at/or below 41		each resident receives and is provided food prepared by	
	degrees for chick	ten salad sandwiches and		methods that conserve nutriti	ve_
	coleslaw on the l	unch time tray line. This		value, flavor, and appearance	; and
	had the potential	to effect 31 of 31		food that is palatable, attracti	
	residents current	ly residing at facility.		and at the proper temperature	I
				1.What corrective action will accomplished for those reside	
				accomprished for those reside	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETI	
		155417	B. WIN	IG		09/09/201 ⁻	1
NAME OF	PROVIDER OR SUPPLIEF	8		1	DDRESS, CITY, STATE, ZIP CODE		
	V 00551/ AT 0007	-T00,UD0		1	GARDNER AVE		
HICKOR	Y CREEK AT SCOT	ISBURG		SCOTT	SBURG, IN47170		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	:			found to have been affected by	<u>the</u>	
					<u>deficiency?</u> No residents were found to be		
	On 9/8/2011 at 1	1:55 a.m., the tray line			affected. Foods which tested at	an	
	items included, b	out were not limited to;			unacceptable temperature were		
	chicken salad sa	ndwiches on wheat bread			removed promptly and discarde	· I	
	and coleslaw. Te	emperatures on tray line of			replacement was provided		
	chicken salad sa	ndwiches, indicated a			immediately.		
		1.4 Fahrenheit [F] and of			-		
	1 ^				2567 pg. 13 indicates that		
	the coleslaw, which had a temperature of 50 degree F. Cook # 1 also took				requested temperature logs was lacking for 9/5 through 9/9/11.		
					is incorrect in that the logs we		
	temperatures at the same time which				located on the back of the kitc		
	indicated readings of 60 degrees F for the				door and facility copies indica	<u>te</u>	
		ndwich and 61 degrees F			they are complete and within		
		Cook # 1 removed			policy guidelines. (See attache	<u>d)</u>	
		and retrieved a new			Food temps were acceptable wh		
		ich indicated results of 59			taken out of kitchen, per cook a		
	degrees F and 62	2 degrees F.			facility documentation. When	iiu	
					residents were waiting for food	_	
	On 9/8/2011 at 1	2:10 a.m., the Dietary			temps to be re-checked, Survey	or_	
	Manager indicat	ed that the cook "just took			told Administrator and DSM to		
	temps [temperate	ure]."			ahead and start tray line to allow		
					residents who were already wai	ting_	
	On 9/8/2011 at 1	2:12 a.m., Cook # 1			to proceed.		
		e had "just took the temps			Thermometers were calibrated		
		ing the food out to tray			immediately.		
	ا ،	re below 40 degrees F."			2.How will the facility identify	_	
		to delaw to degrees 1.			other residents having the		
	On 9/8/2011 at 1	2:15 a.m., during an			potential to be affected by the		
	observation of the	-			same practice and what correction will be taken?	etive	
		•			action will be taken? All residents had the potential t	n he	
	temperatures we				affected by this practice. As sta		
		ent the sandwiches back to			previously all dietary staff has l		
	kitchen and new				in-serviced on how to check, w		
		e brought out. A new			check and how to document foo	od_	
	temperature of the	ne sandwiches resulted in			temperatures, and policy on		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLE	
		155417	B. WING			09/09/20)11
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
			I .		GARDNER AVE		
HICKOR	Y CREEK AT SCOT	ISBURG		SCOTIS	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		1	DATE
		nd the results were shown			thermometer calibration. Additi education was completed one o		
	to the Dietary Manager.				and in a group on 9-20-11.	ii one	
					3.What measures will be	put	
	On 9/8/2011 at 1	_			into place to ensure this		
		e tray line, residents were			practice does not recur?		
		but not limited to;			All dietary staff has been in-ser	viced	
		d Dietary Manager. 4			on how to check, when to check		
	residents were of	oserved to have been			how to document food temperar		
	served before the	e process was stopped and			including thermometer calibrati		
	the Administrator and Dietary Manager				Additional education was compone on one and in a group on	leted_	
	was informed the chicken salad				9-20-11.		
	sandwiches and o	coleslaw could not be			 		
	served based on t	their respective			A Thermometer calibration log	<u>has</u>	
	temperatures.				been posted. The DSM or her	.	
					designee will check the logs at	each_	
	On 9/8/2011 at 1	:30 p.m., observation of			meal and make adjustments as indicated.		
	the 3 thermometer	ers used to test the food			<u>marcuted.</u>		
	items, including	the 2 by the facility, were			The Dietary Services Man	ager	
	placed in a glass	of ice water.			or designee will conduct		
	Thermometer # 1	of facility was observed			random checks daily on		
	to be at 38 degree	es F and thermometer # 2			varying shifts 5 days per w	eek	
	of the facility wa	s observed to be at 40			for 60 days, then 3 times p		
	degrees F. The th	nird thermometer used			week for 30 days to ensure		
	was observed to	be at 33.1 degrees F.			food temperatures have be		
		-			taken and documented. Sh		
	On 9/8/2011 at 2	:20 p.m., during an			will also take additional te		
	interview with th	e Administrator, she			herself to verify accuracy.	·	
	indicated that the	e 4 residents who had			<i>y</i>		
	been served the s	sandwiches and coleslaw,			A Teachable Moment (disciplin	<u>e)</u>	
		nes and coleslaw removed			was given to the DSM regardin	g the	
		een consumed and the			need to ensure food thermometer	er is_	
	1	en offered alternatives.			calibrated routinely.	,	
					If the DSM or designee fir	ids	
	On 9/8/2011 at 2	:20 p.m., in an interview			holes in documentation or		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155417	B. WING		09/09/2011
			STREET	ADDRESS, CITY, STATE, ZIP CODE	!
NAME OF I	PROVIDER OR SUPPLIER		1100 N	GARDNER AVE	
	Y CREEK AT SCOT		SCOTT	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	· · · · · · · · · · · · · · · · · · ·	Manager, she indicated		differences with the	
	that she did not k	know when the		temperatures the DSM or	
	thermometers ha	d been last calibrated.		designee will immediately	7
				review area of concern wi	th
	On 9/9/2011 at 1	2:30 p.m., review of the		dietary staff involved and	
	Policy of Meal T	emperatures presented by		replace food items indicat	ed.
	1 *	r indicated, but was not		Once the resident's needs	I
		mometers may be tested		been taken care of, the DS	SM
		or ice water for a		will address the identified	
	1	grees." "Chilled foods		issue(s) with the involved	
	,	elow 40 degrees F		staff, including re-training	I
		nsure [sic] service		necessary and progressive	
	-				
	_	t so not exceed 42		disciplinary action for	
	degrees F."			continued noncompliance	I
				The DSM or designee reviewir documentation and taking addi	
		2:50 p.m., a record		temps will complete the QA au	
	review of reques	ted temperature logs		form F364 at least 5 days per v	
	indicated docum	entation was lacking for		and bring the results to the	
	9/5 through 9/9/2	2011.		interdisciplinary team meeting	at the
				next scheduled morning manag	· · · · · · · · · · · · · · · · · · ·
	3.1-21(a)(2)			meeting that is held at least 5 d	<u>ays</u>
				per week.	
				These processes and revie	
				will continue on an ongoing	ng
				basis.	
				4.How will corrective action b	
				monitored to ensure the defic	
				practice does not recur and w	<u>nat</u>
				OA will be put into place? The DSM will bring the results	of the
				QA audits to the monthly QA&	
				Committee meeting that is atte	
				by the medical director for revi	
				and recommendations.	
				The QA audit-364 will be	done
				5 days a week for 60 days	,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED	
MIDILAN	OI COMMENTON	155417	A. BUILDING		09/09/2011
		100417	B. WING		03/03/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE	
HICKOB,	Y CREEK AT SCOT	TSBURG		SBURG, IN47170	
				1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		,		then weekly for the next 3	0
				days. At that time, the aud	I
				tool will continue at a	
				frequency determined by t	he
				QA&A Committee, and ca	
				discontinued by the QA&A	I
				Committee when 100%	
				compliance is achieved.	
				This process and review of	f the
				temperature logs and	
				additional temperature che	ecks
				will continue on an ongoir	
				basis even when documen	·
				audits are no longer requir	
				by the QA&A Committee.	
				_	
				<u>Date of compliance: October 8</u> 2011.	<u>3.</u>
				-	
F0371	The facility must -	rom sources approved or			
SS=F		ctory by Federal, State or			
	local authorities; a				
		, distribute and serve food			
	under sanitary cor		F0271	E271	10/00/2011
		review, observation and	F0371	<u>F371</u>	10/08/2011
		ility failed to ensure that		It is the policy of this facility t	<u>o</u>
		ad been opened and/or ad been properly labeled		store, prepare, distribute and	
		to ensure that 3 pitchers		food under sanitary condition	<u>s.</u>
	in the refrigerate	•		- 1.What corrective action will	be
	_	own origin on the		accomplished for those reside	
	•	d properly covered to		found to have been affected by	<u>v the</u>
		ntamination; and failed to		deficiency?	
	•	ted food product. This		No residents were affected.	
	arspose or outdat	ica 100a product. Tilis		110 residents were affected.	

'		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155417	B. WIN			09/09/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	TE COMPLETION DATE
IAG			+	IAG	1	
		e had the potential to			Items found stored incorrectly i refrigerator were discarded	n the
		esidents who currently			immediately. 3 pitchers with lid	ls in
	reside in the facil	lity and received meals			the refrigerator that did not seal	
	prepared in the fa	acility kitchen.			completely and whose contents	
					leaked onto spout and dried wer	
					discarded and replaced. Items the	<u>nat</u>
	Findings include	•			were found without label of dat	e and
		•			contents were discarded	
	On 0/6/2011 at 0	:30 a.m., during the			immediately.	
		. •				
		kitchen refrigerator it			2.How will the facility identify other residents having the	_
	· ·	limited to, the following			potential to be affected by the	
	food items witho				same practice and what correct	
	identifying label;	· •			action will be taken?	
	1. a large approx	imately 2 quart container				
	of brown gelatine	ous substance that the			All residents have the potential	to be
	Dietary Manager	identified as gravy			affected by this practice.	
		2 3			-	
	2 a container of	cottage cheese 64 ounce			Administrator or her designee v	
	(oz) one quarter	_			audit dietary department during	•
	(02) one quarter	iuii			rounds and record findings on f QA F371.	orm_
	2 (4 ::1	0:1.1.			<u>QAF3/1.</u>	
		er of pink substance			During daily rounds, if any staf	fis
	marked milk sha	ke			observed not to follow the facili	
					policies and procedures in regar	_
	4. two 64 oz pitc	hers of iced tea # 1 half			storing, preparing, distributing a	and_
	full and # 2 full				serving food under sanitary	
					conditions, the DSM or her desi	
	5. a large approx	imately 2 quart container			will stop the staff person at that	time,
		ace that the Dietary			and immediately have him/her	
		ed as barbecue sauce			correct the area of concern.	
		ca as surscene suuce			Once that is done, the DSM wil	1
	6 0 10========	-imataly 2 aroutt-i			in-service the staff involved on	-
	6. a large approximately 2 quart container				facility policy and procedure fo	
	of unidentified fo	ood for Resident # 30.			storing, preparing, distributing	I
					serving food under sanitary	
	Two 64 oz pitche	ers of iced tea and a 64			conditions. She will also render	<u>. </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/09/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	but were missing	ed milk shake had covers the spout cover allowing ofference open to air and		progressive discipline for cont noncompliance.			
	each of these cov	vers had black, green, bink substances around		3. What measures will be into place to ensure this practice does not recur?			
		nately 2 quart container of sauce dated 6/6 was gerator.		As stated above, Administrato designee will conduct daily ro and audit dietary department a record findings on form QA F	unds nd		
	of the dietary's d dated from 8/1/2 documentation the "Discard outdate On 9/6/2011 at 1 with the Dietary that she was resp tasks were done	0:40 a.m., record review aily cleaning schedules 011 to 8/28/2011 lacked nat the area marked d food" had been done. :10 a.m., in an interview Manager she indicated consible to ensure that and paper work had been upon completion of task.		During daily rounds, if any star observed not to follow the fact policies and procedures in registoring, preparing, distributing serving food under sanitary conditions, the DSM or her dewill stop the staff person at the and immediately have him/her correct the area of concern. The Administrator in-serviced dietary staff on the policy and procedure to store, prepare, distribute and serve food under	ility ards to c and signee at time, all		
	of [name] facility position title Die section "B. Dieta included, but wa exceed Company federal regulation under section "C Serving Function limited to; "er	1:04 a.m., record review y job description for tary Supervisor, under ary Services Functions" so not limited to; "Meet or y policies and state and as regarding sanitation" Food Preparation and as" included, but was not assuring proper storage of food"		sanitary conditions one on one group on Sept. 20, 2011. The Dietary Services Manager designee will perform random observations, including tray lit temperatures, 5 day per week days, then 3 times per week for days to ensure temperatures are levels appropriate for serving residents. The DSM or her deswill complete the QA audit for F441 at least 5 days per week bring the results to the	or or one one one of on		

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
	155417		B. WIN			09/09/2	011
		<u> </u>	_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	<u>t</u>		1100 N	GARDNER AVE		
HICKORY CREEK AT SCOTTSBURG					SBURG, IN47170		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	, ,		DATE
TAG	"Dietary Service Checklist" include to; under section Plant, *cleaning by the Dietary Mobeing completed Service, *food state leftovers" were to no 6/22/2011. "COOK TRAIN included, but was section "2. Meal & labor [sic] stores and the section of	s Manager Skills ded, but was not limited "4. Sanitation/Physical schedules" was initialed lanager on 6/22/2011 as . "Food Preparation and torage, *handling of both dated as completed ING CHECKLIST" s not limited to; under Preparation *cover, date, red foods", under section Line and Meal Service od storage". Checklist 010 by the Dietary ed she had been trained.		TAG	interdisciplinary team meting at next scheduled morning manage meeting that is held at least 5 days per week. These processes and review will continue on an ongoing basis. 4.How will corrective action be monitored to ensure the deficit practice does not recur and when the put into place? The DSM will bring the results QA audits to the interdisciplinate team meeting 5 days per week, the monthly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-F441 will be done 5 days a week for 60 days, then weekly for the results at the tool will continue at a frequency determined by the QA&A Committee, and can discontinued by the QA&A Committee, and can discontinued by the QA&A Committee when 100% compliance is achieved. This process will continue an ongoing basis even when	the ement ays ws ag e ent hat of the ry and e mext audit he an be A on	DATE
					documented audits are no longer required by the QA	&A	
	l						

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/09/2011	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	The facility must meach resident in acprofessional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screstate; and progres Based on record facility failed to medication order checks were completed and 2 of 10 residents (Residents (Resident #6 on 9 indicated the residents (Resident #6 on 9 indicated the residents (Resident #6 on 9 indicated the resident residents (Resident #6 on 9 indicated the residents (Resident #6 on 9 indicated the resident #6 on 9 indicated the residents residents (Resident #6 on 9 indicated the resident #6 on 9 indicated the residents residents (Resident #6 on 9 indicated the residents Resident #6 on 9 indicated the residents residents (Resident #6 on 9 indicated the residents Resident #6 on 9 indicated the residents residents (Resident #6 on 9 indicated the residents Resident #6 on 9 indicated the residents	naintain clinical records on accordance with accepted ards and practices that are ely documented; readily estematically organized. must contain sufficient tiffy the resident; a record of essments; the plan of care ded; the results of any ening conducted by the is notes. review and interview, the ensure changes in s and pulse monitoring eplete, accurately for readily accessible for in a sample of 10 ents #6 and 28) reviewed reders, and 1 of 4 residents ghts in a sample of 10 ent #1) clinical record for /8/2011 at 10:05 a.m., dent had diagnoses			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	DATE 10/07/2011 o ach ds te; lv ll be ats v the	
	· ·	out were not limited to, steoarthritis, immobility steoporosis.			2011. 2. The MD was notified of puls checks for Resident #28 on 9/9/MD gave a new order to discondaily pulse checks and to check	<u>e</u> /11. tinue	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MNMZ11 Facility ID:

D: 000421

If continuation sheet

Page 25 of 31

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED
155417		155417	B. WIN			09/09/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIER	R.			GARDNER AVE		
HICKORY CREEK AT SCOTTSBURG			1	SBURG, IN47170			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORR			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		e consultant pharmacist			every other day with Digoxin of	<u>n</u>	
	made a recomme	endation for the physician			<u>9/9/11.</u>		
	to re-evaluate the	e resident's Motrin [a			The DON will provide re educa	tion	
	non-steroid anti-	inflammatory drug] 400			to the nurses/QMAs on 9/28/11		
	mg [milligram] I	BID [twice daily] due to			include review of Pharmacy		
	long term use be	ing associated with			recommendations and transcrip		
	1 -	ressure, worsening			of orders for medication change	es and	
	_	cardiovascular events			vital sign monitoring.		
	and GI effects."				4 Danidant # 12 diatamana		
	una Grenous.				4. Resident # 1's dietary progre note was corrected to address he		
	On 8/26/2011 th	ne physician agreed and			weight.	<u> </u>	
					<u></u>		
	1 -	r to decrease the Motrin			2.How other residents having	the_	
	to 200 mg po [by	mouth] BID.			potential to be affected by the	<u>.</u>	
					same practice will be identified		
		ugust MAR [Medication			and what corrective action(s)	<u>will</u>	
		Record] indicated the			be taken?		
	order was not pu	t into effect until			1. A Pharmacy recommendation	,	
	8/30/2011. Durir	ng an interview with the			audit was completed on 9/12/11		
	Director of Nurs	ing [DoN] on 9/8/2011 at			other residents were found to be		
	2:00 p.m., she in	dicated one of the nurses'			affected by this alleged deficien	ı <u>t</u>	
	found the consul	tant's recommendation			practice.		
	and the physician	n's response on a clip			2. An audit will be conducted by		
		er which was why the			9/30/11 on all monthly rewrites make sure that they are accurate		
	medication was i	•			preparation for the review of the		
		lso indicated the nurse			October monthly physician order		
		e needed to write an					
	order.	theeded to write an			As the DON is reviewing the		
	oruci.				September monthly physician o		
					and any physician orders subsec	_	
					to it, she will identify any issue		
		clinical record for			concerns regarding physician or and will make sure that the physician		
		9/7/2011 at 3:15 p.m.,			is notified, as necessary, for	oiciail_	
		ident had diagnoses			clarification. Once the orders ar	·e	
	which included,	but were not limited to,			complete and accurate, the DO		
	coronary artery of	disease, atrial fibrillation			review the facility's policy for	_	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
and plan of correction libertification 155417			A. BUIL	DING	00	09/09/2	
		133417	B. WINC			03/03/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HICKORY CREEK AT SCOTTSBURG					GARDNER AVE SBURG, IN47170		
		TATEMENT OF DEFICIENCIES	\dashv	ID			(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	l,	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	DATE
	and hypertension				transcription and following of		
	31				physician orders with the nurse(<u>(s)</u>	
	The 2011 Septem	ber monthly physician			involved. She will also render		
	_	the resident had an order			progressive disciplinary action is continued noncompliance.	tor_	
		for pulse checks every			сопиниси попсотриансе.		
		he May to August 2011			3. An audit will be conducted by		
	l -	cumentation of the pulse			9/30/11 on all dietary progress i	notes.	
	being monitored	•			- 2.3371 /		
		-			3.What measures will be		
	During an intervi	iew with the DoN on			into place or what system	<u>11C</u>	
	9/9/2011 at 11:00	a.m., she indicated she			changes will be made to		
	was not aware th	e pulse was not being			ensure that the deficient		
	monitored daily	per physician orders and			practice does not recur?		
	would need to ca	ll the physician to			The DOM: 11 and 15 at 15 at	,	
	determine the rea	asoning for it being			The DON will review the 2		
	monitored daily	and if he wanted it to			hour report, focus charting		
	continue to be m	onitored daily.			Medication Administration		
		•			Record, and Physician order		
					at least five times a week a		
					part of her daily tour of du	ιy.	
					Pharmacy recommendation	25	
					will be given to the nurses		
					fax to the MDs. The MDs		
					do not receive faxes will be		
					called in regards to the	۱	
					recommendations. If no		
					response is received within	$_{,24}$	
					hours, the Physician will b		
					contacted by phone for fol		
					up. The DON will in-servi		
					all licensed nurses on this	re	
					policy on 9/28/11.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	COMPLE	
ANDILAN	or connection	155417	1 ' '	LDING	00	09/09/20	
		100411	B. WIN	_	Paraga gray gray	03/03/20	••
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
HICKUD	Y CREEK AT SCOT	TSBURG		1	GARDNER AVE SBURG, IN47170		
				L	000100, 11447 170		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE RED CEDED BY ELLI		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	REGULATORIOR	ESC IDENTIFICATION OF THE STATE	+	1710	At least five days per weel	-	DITTE
					the DON or designee, will	I .	
					review the 24 hour report,		
					focus charting, Medication		
					Administration Record, an		
						iu	
					Physician orders for any outstanding recommendati	ons	
					or change of orders. The I or designee will document		
					findings on audit tool QA	I .	
					form F282, five days per v If the DON identifies	veek.	
					recommendations not		
					addressed by the Physician	I .	
					new orders not processed,		
					will immediately ensure th	I .	
					attending Physician is noti		
					and process any orders. Or	I .	
					they have been corrected,		
					DON will re train the staff		
					member(s) involved. In		
					addition, progressive		
					disciplinary actions will be	9	
					taken for non compliance.		
					The DD/DCM11		
					The RD/DSM will correct	- 1	
					discrepancies regarding w	eignt	
					documentation.		
					- 4.How will corrective action b		
					monitored to ensure the defici		
					practice does not recur and w		
					QA will be put into place?	_	
					_		

000421

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER: 155417	A. BUILDING	00	(X3) DATE SURVEY COMPLETED 09/09/2011			
NAME OF F	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE	03/03/2011			
HICKOR'	Y CREEK AT SCOT	TSBURG	SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	review of Reside not limited to; di chorea and obesi Monthly/Annual record indicated, weight for May h	e was 195 lbs, July was was 193 lbs and		The DON or designee will bring QA audits to the clinical review meeting 5 days a week. In addithe results of the QA audit tool be reviewed weekly at the Start of Care meeting and monthly a QA committee meeting for the months. The Dietary Services Manager will also bring the residents' weights to the QA Committee monthly for the nemonths. The QA committee will determ the continued frequency of the audit tools after the 3 month tiperiod once the facility demon 100% compliance. However, the review process as outlined abortonium on an ongoing basis, when the Committee no longer requires a written audit. Date of compliance is October 2011.	ition, will ndards at the next 3 sults of xt 3 nine QA me strates he ve will even f			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/09/2	ETED	
	NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET A	DDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	<u> </u>	
	SUMMARY S (EACH DEFICIENT REGULATORY OR Review of the "D NOTES" dated 8 was not limited to [weight] (symbolis 140 # [pounds] 6/11 143, 7/11 14 loss." On 9/6/2011 at 5 with the Dietary about the charting remained silent a comment. On 9/9/2011 at 1 Dietary Services under section "6. *assessments-inisigned by the Die 6/29/2011 indicated been completed. On 9/9/2011 at 1 Administrator prodietary progress is which indicated dietary note was 8/4/2011 at 193 # 30 days. Wt on 9 recorded on wron [significant] wt (TSBURG TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) DIETARY PROGRESS /15/2011 indicated, but o; "Sig [significant] wt l for change) - current wt l. Past weight 5/11 146.5, l6.6 a 4.1 % [percent] :50 p.m. in an interview Manager, when asked g discrepancy she nd did not give any 1:04 a.m., review of the Manager skills checklist Clinical/Nutritional tial, quarterly" dated and etary Manager on ted that this skill had		1100 N	GARDNER AVE	TE	(X5) COMPLETION DATE
	last 180 days."						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417	(X2) MULTIPLE CC A. BUILDING B. WING	00		E SURVEY PLETED [2011		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE		
	3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)							